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THE CHRONIC DRUNKENNESS OFFENDER

CHAPTER XV

PSYCHIATRIC ASSESSMENT

Milo Tyndel, M.D., Ph.D., F.A.P.A.

Project 52

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CONTENTS

	Page
REVIEW OF THE LITERATURE	1
METHOD	7
The Sample	7
The Interview Setting	8
The Structure of the Interview	9
The Use of Other Data	10
PREVALENCE OF PSYCHOPATHOLOGY AND PSYCHIATRIC DISORDERS	13
The Toronto Sample	14
a) Psychotic Disorders	14
b) Psychoneurotic Disorders	15
c) Personality Pattern Disturbances	16
d) Personality Trait Disturbances	17
e) Sociopathic Personality Disturbance	19
f) Additional Features	19
Comparison with Other Studies	21
PSYCHOPATHOLOGICAL CONSIDERATIONS	24
ALCOHOLISM IN THE SAMPLE	27
CIVILIZATION AND THE INDIVIDUAL	32
Theory of the Chronic Skid Row Alcoholic	37
THE NATURE OF THE OFFENCE	41
PROGNOSIS AND RECOMMENDATIONS	44

TABLES

XV - 1	PSYCHIATRIC DIAGNOSIS - TORONTO SAMPLE	Pages 11 and 12
XV - 2	PSYCHIATRIC DIAGNOSES OF THREE GROUPS OF DRUNKENNESS OFFENDERS	22

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CHAPTER XV

PSYCHIATRIC ASSESSMENT

REVIEW OF THE LITERATURE

A chronic drunkenness offender is a person who has been repeatedly convicted for the offence of "being intoxicated in a public place" (55). He is frequently referred to as the "Skid Row alcoholic", "the homeless alcoholic", or the "chronic police case inebriate", the terms being used interchangeably. The repeated process of arrest, conviction, incarceration, and release, is sometimes referred to as the "revolving door".

The student of the chronic drunkenness offender is bound to raise the following question: What makes a person sink not only to the very bottom of the social ladder but makes him spend the rest of his life commuting back and forth between Skid Row and jail? A simple answer would be to blame this deterioration entirely on excessive drinking. However, this does not take into consideration that the majority of people who use alcoholic beverages to excess do not end up as chronic drunkenness offenders. It is therefore only logical to expect serious psychological and social influences to be at work in the selection of individuals for this fate.

Some of the relevant theories concerning the psychology and psychopathology of the Skid Row alcoholic will be reviewed as a background for the discussion of our findings. While the literature on the psychology of the alcoholic is relatively rich, psychiatric studies concerning specifically the chronic drunkenness offender - the person on Skid Row whose existence is dominated by excessive drinking and repeated arrests - are few. The studies summarized below appear to be representative in that they use dynamic viewpoints and attempt to establish connections between the fully developed person of the chronic drunkenness offender on the one hand and his background and environment on the other. Although these presentations are quite helpful in outlining the personality of the chronic drunkenness offender and

thus contributing to our understanding, they fail to deal adequately with the pathogenesis of the abnormal outcome. Many questions about the origin and development of the personality of the chronic drunkenness offender remain unanswered.

In his attempt at describing the psychological characteristics of the Skid Row alcoholic, Myerson concluded:

> Whether the years of giving in to their desires have led to the alcoholic personality or whether this personality itself leads to alcoholism, no one knows for certain. Nevertheless, these men exhibit certain general characteristics that create problems in any therapeutic situation. Thus, the tendency to blame others, the bursts of hostility upon the slightest frustration and the extraordinary sensitivity to what others may think make them appear almost paranoid at times. Another common characteristic is an insatiably demanding nature. People who try to deal with such a patient must be careful not to give in to any of his demands, for once this happens, the demands may well continue beyond reasonableness. When finally he has to be refused, he bursts into rage and projects the blame on those around him. They, in turn, lose patience and have nothing further to do with him. Although hostile reactions are inevitable, anger should not lead to punitive measures. It is a certainty that throughout the life of the alcoholic patient all forms of punishment, threats, desertion and incarceration have been tried, all without success (47, p.647).

Myerson (48) emphasizes that the Skid Row alcoholic's past failure in his interpersonal relations is the key to understanding his present isolated life. In the exchange of human relations he has made insatiable demands on others but has been unable to give in return. He has been capable of loving others or regarding them as friends only as long as they have met his unreasonable demands. Eventually he has alienated everyone and sinks to Skid Row, finding his way to the protection of jail or hospital when exhausted.

This is how Myerson describes the manifestation of this personality in the hospital setting:

> During this period of partial protection, which often lasted for months, the men found it relatively easy to give up liquor. It was rare for any of them to break the rule of no drinking on the hospital grounds. Sooner or later, the pressure of loneliness motivated them to try to restore themselves to the remaining members of their families. This attempted restoration demonstrated again the alcoholic patient's own failure in his human relations. Denying his inadequacies, the passage of time and other factors, such as divorce, he still expected love and devotion from those who had loved him previously. He fell immediately into his former pattern of "all take and no give". His unreasonableness led to the inevitable rejection, the one thing he could not tolerate or understand. This rejection frequently became his rationalization for drinking again (48, p.8).

In his clinical observations on alcoholic prisoners, Myerson (49) also emphasized the importance of continuous emotional deprivation and overwhelming fear. They use alcohol for a multitude of related subjective reasons: to allay the fear of isolation, for sedation, to find companionship, as consolation for the feelings of emptiness, and as a means of controlling impulsiveness.

Studying the psychodynamics of the Skid Row alcoholic, Rosenman (53, 54) stresses the narcissistic and masochistic features as shown in the Skid Row alcoholic's fantasies and mode of living. This man appears to operate on the basic unconscious assumption that he has been emasculated by a woman. Because of his conviction that he cannot successfully steal a powerful man's virility - the only way to regain his lost masculinity and thus be able to compete in a world populated by powerful male figures - he finds alternate solutions in his fantasies. By exhibiting his misery to a powerful male, he hopes that the latter, moved by pity and love, will thereafter protect him. He is also willing to undergo castration and be the female in a sexual relationship. Another set of fantasies shows him possessing large fortunes or being armed or of strong physique. By fleeing into helplessness he would

magically force others to help him. Living in misery serves to reinstate the initial trauma of rejection by the parental figures.

In Rosenman's words, "Being a Skid Row inhabitant, as well as a drunkard, allows the patient masochistically to act out the schema of one who is both irreparably deprived and irreparably injured" (54). Skid Row and alcohol are joint routes of escape into anonymity, and a kind of death. In the author's view, a splitting of the self-structure takes place, whereby the negative image of the self is both dominant and more extensive than the positive self-image. The self-destructive acts of the patient appear to be frequently guided by the negative ego images which are a condensation of the perception of his inferiorities and the instrument of his guilt.

Feeney, Mindlin, Minear and Short (18) described the characteristics of "chronically jailed alcoholics" as compared to "cooperative alcoholic clinic patients". They found that the jailed inebriates' past adjustment, present social resources, and motivation to change, were all poor. They had a strong dependency on living at the Workhouse (i.e. the jail) and returning there. The psychiatric diagnoses revealed some deterioration and lack of the ego strength that would enable them to live outside the institution. They were accident prone, which was in keeping with their marked dependency needs. On the other hand, psychosomatic symptoms were found less frequently in the inmate group than in the clinic group and they had fewer of the severe alcoholic reactions. The authors suggest that: "Signs of deterioration in the Workhouse group, whether mental, socioeconomic or motivational may be traced to problems other than advanced stages of alcoholism".

Levinson (40) has studied the psychology of the homeless man who does not accept the ordinary norms of our community, rather than the drunkenness offender as such. Since the homeless man has removed himself from many of the community's external and internal sanctions and controls, he is not affected by the prized awards and dreaded punishments. He has been negatively reinforced in his attempts to acquire a socially accepted status (27), and consequently has given up the battle for acceptance in the form either of acquiring a new social status or reestablishing the one he once had. He is now rarely disturbed by rejection. Contrary to

the general impression, he is not looking for a life of ease and a protected environment. He just wants to exist with the least effort and to be self-sufficient. He is indifferent to external reality and to his inner world of emotions, of time, and of questioning himself. He has little internalized anxiety and therefore few clinical manifestations of anxiety.

According to Levinson, the homeless man's psychosexual development was poor, leading to reluctance to sharing or accepting affection. Due to ambivalence and anxiety brought about by the mother figure he equated love with being hurt, rejected and deserted. He withdrew into passivity. Due to poor development of his ego he finds it difficult to satisfy his instinctual needs on a reality basis, but he prefers his freedom to security even if it is only freedom to starve or to beg. He takes on only nonresponsible short term jobs, avoiding occupations which may cause self-involvement. The fact that the homeless man is usually found in the age bracket 35 - 50 is explained by the long time it takes to become homeless and to develop the necessary "professional" attitudes appropriate to the role. In Levinson's view the homeless man is emotionally disturbed but he can not be considered as being in thralldom to a disease process once we look at him as a cultural deviant and as the end product of moral, social and family crises.

The "undersocialization" theory espoused by several sociologists is of relevance here because it attempts to explain the same phenomena without explicit reference to psychodynamics or psychopathology. The Skid Row inebriate's present inability to cope is seen as a deficiency of social skills and is attributed to earlier deficiencies - never clearly defined - in socialization both in the family and in adolescent peer groups.

In Bacon's fundamental study of the sociology of the drunkenness offender (2) a large number of persons convicted of drunkenness were compared with petty offenders and with the general male population. They were found to be predominantly middle age men belonging to few organized groups, participating in few of the normal recreational activities. Bacon attached special significance to the high proportion unmarried or separated from their wives. This relative social isolation, which Bacon called "undersocialization" he believed to have preceded the onset of inebriety. Thus drunkenness was both a symptom of undersocialization and a pattern of behaviour that aggravated the condition.

Bacon pointed out that:

> Membership in any association serves more or less to provide the individual with satisfactions, to confine his activities to what may be termed conventionalized channels of behaviour, to encourage activities which offer societal rather than individual benefits, or which promise satisfactions only after long effort or potential delays. (2)

The undersocialized man lacks both the satisfactions that derive from memberships and the social controls. He is free to use alcohol as an apparent shortcut to the pleasures of membership and accomplishments that he lacks.

Following up Bacon's idea, Straus (64) interviewed 203 men in a Salvation Army hostel. He found that 88 per cent were excessive drinkers. Heavy drinking had preceded and seemed to be a contributing cause of homelessness for two-thirds of the men, while for the other third, heavy drinking followed and seemed to have resulted from the condition of homelessness and other related factors. In his opinion, by joining the ranks of the homeless, the man who is already undersocialized can escape into an environment where little is expected of him and where he can reduce to a minimum contacts that will remind him of his inadequacies. Through excessive drinking the undersocialized man can achieve, at least for a time, very real impressions of social participation and adequacy, which are otherwise unobtainable to him.

Pittman and Gordon (51), in a study of 187 "chronic" police case inebriates, further elaborated the undersocialization hypothesis. They interpreted apparent shortcomings in the subject's family of birth as evidence of early undersocialization. Deficiencies in the early family experience were seen in the infrequency of interaction among family members, the lack of family participation in community activities, the frequency of homes broken before the subject's fifteenth birthday, and various signs of deprivation in parent-child relationships. The men verbalized feelings of dissatisfaction with their original home situation and the absence of a sense of belonging in relation to their families. Furthermore, the authors found

evidence of a lack of participation in social activities as adolescents - a participation that might have made up for earlier deprivations. The result of this early undersocialization was an inability to cope with adult roles, leading to drinking and Skid Row.

The undersocialization theory has led to a useful mustering of facts about the early deprivations of chronic drunkenness offenders and the subsequent failures of these men in occupations and primary relations, but the theory does not provide the concepts to analyze the psychodynamics linking these situational phenomena. Nor does this somewhat ambiguous but allusive concept do justice to the details and variations of current psychopathologies among drunkenness offenders. None of the writers define "undersocialization" with sufficient precision to make possible its translation in terms of psychodynamics. They appear (like the early instinct theorists) to be positing - without independently establishing - a subjective counterpart to explain an observed pattern of behaviour. Since the chronic drunkenness offenders "undersocialize" in the sense that they do not participate in normal relationships and activities, they must be the victims of a psychological state called "undersocialization".

METHOD

The Sample

A total of 237 subjects defined as "chronic drunkenness offenders" - men having three or more convictions for public intoxication during the preceding 12 months - were interviewed in the Toronto jail during the period from November 1st, 1960 to October 31st, 1961.

As a result of the sampling method it appeared clear that the group under investigation comprised a high percentage of persons fully integrated into Skid Row as well as a high proportion of chronic alcoholics (Chapters VII and XI).

The Interview Setting

The interviews took place in special rooms in the Toronto Jail (known as the "Don Jail"). No specific amount of time was allotted for an interview but each was given as much time as was deemed necessary to obtain adequate information. The psychiatric interview took place privately, without witnesses; interviewer and subject faced each other, the latter usually smoking cigarettes. The atmosphere was as relaxed as possible under the circumstances. The examiner postponed taking notes until after completion of the interview. The subject was encouraged to speak as freely as possible, the direction of the talk being guided by questions or remarks whenever it was deemed necessary. The subject was assured that the examiner had no previous information about him and that the conversation would be considered confidential. In the majority of cases it was possible to establish a good working rapport in a relatively short time, even in the case of previously reluctant individuals.

During each interview the subject was offered cigarettes. Several men asked for some more cigarettes to take to their cells. A few asked for money, which was refused and some asked for advice and assistance in the future.

The setting was obviously quite different from that in which psychiatric interviews usually take place. It is safe to assume that these differences would have some bearing on the picture obtained and this has been given consideration in the evaluation.

The atmosphere was noticeably different in the case of one subject who was interviewed in the Alex. G. Brown Memorial Clinic, to which he had been transferred. Although the clinic is part of a reform institution, the inmates are given a considerable amount of freedom, privileges and occupation. More important, however, is the fact that the atmosphere is that of a therapeutic setting rather than of a punitive institution. This was productive of a more relaxed situation wherein both subject and interviewer felt greater ease and rapport was more easily established.

The Structure of the Interview

As far as possible under the circumstances the psychiatric interview tended to encompass a great variety of aspects of the interviewee's past and present life. After information on the subject's current status had been elicited (age, marital status, etc.), the area of complaints and functional inquiry was covered to the extent deemed necessary to obtain descriptions of symptoms and simultaneously to establish that rapport that would allow us to go into details concerning the past. This was followed by obtaining information on the family history, the interviewee's educational and working record, his past health, and relationships with peers, superiors and the opposite sex. Usually it was not difficult to continue with a drinking history and consequences of drinking, questions concerning manifest or latent homosexuality, marital history, criminal record, and experiences with penal institutions. Some of the interview time was devoted to obtaining a picture of the interviewee's intelligence and possible mental deterioration, and to exploring the possibility of delusions and hallucinations. An effort was made to obtain the interviewee's insight into his condition and his feelings about the law, law enforcement, life on Skid Row and in jail, as well as some basic ideas concerning his outlook on life.

Many of the subjects came with preconceived ideas, suspicions and fears. These were freely expressed by some, while others showed them in their attitudes toward the several interviewers and examiners, revealing overt hostility, rejection and refusal to cooperate. Some subjects were bitter about their arrest and conviction, considering it unjust and giving this as their reason for a reluctance to cooperate. Some were under the impression that their participation in our study would interfere with their anticipated transfer to Mimico Reformatory, where they expected more privileges and better conditions, Some were afraid their statements might be held against them in future court cases or might interfere with their being granted the earlier release from jail that they had applied for. Others expressed their mistrust of any sort of investigation, which they considered useless and hopeless judging from their previous experience with what they thought of as similar investigations.

In each case the social interviewer who saw the man first, explained to the subject the reasons for and the aims of this study, and told him by whom he would be seen. In a

number of instances the men felt threatened at the idea of seeing a psychiatrist, and showed anxiety lest they be considered mentally ill and perhaps committed to a mental hospital. Sometimes a way out of this impasse was the device on the part of the social interviewer of referring to the writer as a neurologist or a "nerve specialist".

On the other hand, the majority of subjects (82.2%) volunteered to participate in our project or agreed to it following friendly persuasion. No attempts were made to put pressure on any reluctant individuals. Frequently the men expressed the hope that our study might be of some help for other people with drinking problems which caused them to become involved with the law, even though it might not benefit themselves. This hope appeared to be sincere in many instances, although insofar as some of the others were concerned one could not help feeling that they were paying lip service.

In a small number of cases the writer's explanation and persuasion ensured the continued participation of the subject. It also happened, in a few instances, that the subject refused cooperation before reaching the stage of the psychiatric interview, apparently under the influence of mounting anxiety caused to a certain extent by traumatic memories evoked by the social interviews and, to a lesser degree, by the psychological tests.

Information was also gathered to the effect that our interviewees were subjected to pressure by criticism and ridicule from other prisoners, mainly from criminals other than drunkenness offenders, but also by some of the latter who were not slated for participation in our project or had refused it. On the other hand, some of our subjects, having completed their investigations, were of beneficial influence on their reluctant fellow prisoners in dispelling their suspicions and fears.

The Use of Other Data

Following each psychiatric interview, and after consulting the reports of the social interviewer, psychologist, medical examiner, the police records, and other pertinent information contained in each file, individual psychiatric reports were written. These reports included a summary of the interview, psychiatric findings, a discussion of the latter with an attempt at

TABLE XV - I

PSYCHIATRIC DIAGNOSIS - TORONTO SAMPLE

Classification*	Additional Features	Number	Per Cent
Psychotic Disorders:			
300.3 Schizophrenic reaction, paranoid type	none	2	0.8
300.7 Schizophrenic reaction, chronic undifferentiated	"	3	1.3
301.2 Manic depressive reaction, other	"	2	0.8
303 Paranoid reactions	"	2	0.8
		9	3.8
Psychoneurotic Disorders:			
310 Anxiety reaction, neurosis or state	"	16	6.8
	organic brain lesion	1	0.4
	speech disturbance	1	0.4
313 Obsessive compulsive reaction	epilepsy	1	0.4
314 Depressive reaction	none	24	10.1
	organic brain damage	1	0.4
	mental retardation	1	0.4
	mental retardation and epilepsy	1	0.4
	sexual deviation	1	0.4
318.5 Psychoneurotic reaction, other	none	38	16.0
	epilepsy	1	0.4
		86	36.3

(Table continued on following page)

*The number on the left is the code number of the International Statistical Classification.

TABLE XV - I cont'd.

Classification	Additional Features	Number	Per Cent
Personality Pattern Disturbance:			
320. Schizoid personality	none	11	4.6
	mental retardation	3	1.3
320.2 Cyclothymic personality	psychopathic personality	4	1.7
320.3 Inadequate personality	none	4	1.7
	organic brain damage, mental retardation, and epilepsy	2	0.8
		24	10.1
Personality Trait Disturbance:			
321.0 Emotionally unstable personality	none	1	0.4
321.1 Passive aggressive personality	none	96	40.5
	suspected brain lesion	1	0.4
	organic brain damage	1	0.4
	mental retardation	1	0.4
	epilepsy	2	0.8
	organic brain lesion and epileptic manifestations	1	0.4
	compulsive features	2	0.8
321.5 Compulsive personality	none	2	0.8
	epileptic manifestations and organic brain damage	1	0.4
321.5 Personality trait disturbance, other	none	1	0.4
		109	46.0
Others:			
320.5 Sociopathic personality disturbance	none	5	2.1
326.4 Transient situational personality disturbance	none	1	0.4
325.5 Mental retardation (only)		1	0.4
Epileptic (only)		2	0.8
		9	3.8
	Total	237	100.0

exploring the psychodynamics involved, diagnosis (psychiatric,form of alcoholism and physical), prognosis, and suggestions regarding rehabilitation. Certain issues were discussed with the members of the team in informal meetings and seminars.

PREVALENCE OF PSYCHOPATHOLOGY AND PSYCHIATRIC DISORDERS

Any endeavour to classify psychopathologic syndromes and to render them usable for statistical evaluation encounters more difficulties than in other medical specialities, for a variety of reasons. Among them is the somewhat higher degree of subjectivity, the lack of unity in psychiatric nomenclature and the influence of the psychiatric observer's specific school of thought. Nevertheless it is felt that for all intents and purposes, a breakdown of the psychiatric findings and a quantitative assessment of the diagnostic categories (neurotic disorders, psychoses, personality types, character disorders) is possible without too much attention being paid to the negligible figures concerning rare or atypical disorders.

The diagnostic terms used in Table XV-1 are those found in the Diagnostic and Statistical Manual. Mental Disorders,[1] American Psychiatric Association, 1952. An attempt was made to arrive at the diagnosis as close to the accepted term as possible under the circumstances. For obvious reasons, however, only the main characteristics could be used leaving much room for overlapping and more than one diagnostic category present in the same individual. A short description of each diagnostic entity based on those given by the manual mentioned above may be helpful for better understanding. Specific classifications are underlined.

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[1] All quotations in this chapter come from this Manual.

The Toronto Sample

a) Psychotic Disorders. - Psychotic disorders "are characterized by a varying degree of personality disintegration and failure to test and evaluate correctly external reality in various spheres". Psychotic patients have serious difficulties in relating themselves affectively to their environment.

In nine cases, or 3.83 per cent, overt psychotic illness was diagnosed. Among them, two subjects or 0.8 per cent of the sample, were diagnosed as suffering from schizophrenic reaction, paranoid type. "This type of reaction is characterized by autistic, unrealistic thinking, with mental content composed chiefly of delusions of persecution, and/or of grandeur, ideas of reference, and often hallucinations". There is "a fairly constant attitude of hostility and aggression". Delusions of omnipotence, genius and special ability as well as hypochondriac ideas are present.

Three subjects, or 1.3 per cent, were found to be suffering from a schizophrenic reaction of the chronic undifferentiated type. Patients in this diagnostic category present "definite schizophrenic thought, affect and behaviour beyond that of the schizoid personality". Patients frequently labelled as "latent", "incipient" or "pre-psychotic" schizophrenic reactions are included in this group.

Two subjects, or 0.8 per cent, presented the clinical picture of manic depressive reaction. This clinical entity comprises those cases wherein the main manifestations of the two phases of the manic depressive reaction (mixed type) occur together, or those cases where continuous alteration of the two phases takes place (circular type).

In the cases in this sample there was a clear history of manic and depressive phases, most likely endogenous in nature. In this type of mental disorder the effects of alcohol are apt to distort and to cover up the psychotic picture. As a consequence, the pathologic behaviour may be blamed on the alcohol rather than on the psychosis and no steps are taken to hospitalize the patient or to provide any type of therapy. If the patient happens to be on Skid Row, he may go unnoticed for extended periods of time since the relationships between Skid Row inhabitants are highly impersonal, and odd behaviour including depression or elation, may be accepted without much concern.

Two subjects, or 0.8 per cent presented a paranoid reaction. This diagnosis is used for those cases "showing persistent delusions, generally persecutory or grandiose, ordinarily without hallucinations. The emotional responses and behaviour are consistent with the delusional ideas held. Intelligence is well preserved".

One patient showed a typical picture of paranoia. This rare condition "is characterized by an intricate, complex, and slowly developing paranoid system, often logically elaborated after a false interpretation of an actual occurrence. Frequently the patient considers himself endowed with superior or unique ability. The paranoid system is particularly isolated from much of the normal stream of consciousness, without hallucinations and with relative intactness and preservation of the remainder of the personality, in spite of a chronic and prolonged course".

Individuals suffering from schizophrenic and paranoid conditions have, by nature of their personality and their condition, increased difficulties in establishing satisfactory interhuman relationships. They are hypersensitive and easily hurt, which adds to their tendency to withdraw. Drinking is apt to give them an opportunity to withdraw from people while gaining the less demanding forms of companionship and comfort that alcohol can provide. Skid Row is the place where interhuman relationships are, to a large extent, limited to the matter of procuring alcohol and the minimum necessities. No questions are asked, and the probability of getting emotionally involved and thus hurt is greatly reduced.

b) Psychoneurotic Disorders. - The main characteristic of these disorders is anxiety which may be directly experienced and expressed or may be unconsciously controlled by a great variety of defence mechanisms, for example, depression or conversion. Unlike psychotic patients those presenting psychoneurotic disorders do not show gross distortion or falsification of external reality, such as delusions or hallucinations. Their personality is not severely disorganized. During their lifetime periodic or constant maladjustment of varying degrees can be demonstrated. Various stress situations may trigger off acute symptomatic expressions of psychoneurotic disorders.

Eighteen subjects, or 7.6 per cent of our sample, presented the symptoms of anxiety reaction, neurosis or state. In this kind of neurotic disorder "the anxiety is diffuse, and not restricted to definite situations or objects ... It is not controlled by any specific psychological defence mechanism ... This reaction is characterized by anxious expectation and is associated with somatic symptomatology".

One subject presented the clinical picture of an obsessive compulsive reaction. In this condition "the anxiety is associated with the persistence of unwanted ideas and of repetitive impulses to perform acts which the patient himself considers morbid". He is able to see his ideas and behaviour as unreasonable, but nevertheless is compelled to act out his rituals.

Twenty-eight subjects, or 11.8 per cent, were diagnosed as suffering from depressive reaction. The presenting symptoms in this type of emotional reaction are depression and self-depreciation. This reaction is precipitated by a current situation, particularly by some loss sustained by the patient. It is frequently associated with a feeling of guilt for past failures or deeds. The extent of this reaction is dependent on the intensity of the patient's ambivalent feelings towards his loss and also on the objective circumstances of the loss. (This condition is to be differentiated from the depressive psychotic reaction).

Thirty-nine subjects, or 16.4 per cent, were diagnosed as psychoneurotic reaction, other. In these cases, the condition was considered psychoneurotic, without, however, the symptoms permitting a proper classification with the more specific type of neurotic disorders.

c) Personality Pattern Disturbances. - Personality pattern disturbances are characterized by developmental defects or pathologic trends in the personality structure. Patients presenting these disturbances show little sense of distress and minor degrees of subjective anxiety. Personality pattern disturbances manifest themselves through life-long patterns of action or behaviour rather than through mental or emotional symptoms and signs.

Fourteen, or 5.9 per cent, of the men were diagnosed as schizoid personalities. "Inherent traits in such personalities are (1) avoidance of close relations with others, (2) inability to express hostility or even ordinary aggressive feelings directly, and (3) autistic thinking. These qualities result early in coldness, aloofness, emotional detachment, fearfulness, avoidance of competition and day dreams revolving around the need for omnipotence. As children they are usually quiet, shy, obedient, sensitive and retiring. At puberty, they frequently become more withdrawn, then manifesting the aggregate of personality traits known as introversion, namely quietness, seclusiveness, 'shut-in-ness', and unsociability, often with eccentricity".

A smaller number of subjects (4 or 1.7%) were diagnosed as cyclothymic personality. Such individuals are characterized by "an outgoing adjustment to life situations, an apparent personal warmth, friendliness and superficial generosity, an emotional reaching out to the environment, and a ready enthusiasm for competition. Characteristic are frequently alternating moods of elation and sadness, stimulated apparently by internal factors rather than by external events".

In six subjects, or 2.5 per cent, the presenting picture was that of inadequate personality. "Such individuals are characterized by inadequate response to intellectual, emotional, social and physical demands. They are neither physically nor mentally grossly deficient on examination, but they do show inadaptability, ineptness, poor judgement, lack of physical and emotional stamina, and social incompatibility".

d) Personality Trait Disturbances. - Personality trait disturbances are diagnosed in those persons "who are unable to maintain their emotional equilibrium and independence under minor or major stress because of disturbances in their emotional development". In some instances the "disturbance is related to fixation and exaggeration of certain character and behaviour patterns"; whereas in others the behaviour expresses "a regressive reaction due to environmental and endopsychic stress".

One other subject was diagnosed as an emotionally unstable personality because he reacted "with excitability and ineffectiveness when confronted by minor stress", and indicated that "his relationship to other people is continuously fraught with fluctuating emotional attitudes because of strong and poorly controlled hostility, guilt and anxiety".

By far the largest group of patients - 104 or 43.9 per cent - were diagnosed as passive aggressive personality. According to the standard nomenclature, the types of reactions mentioned below "are manifestations of the same underlying psychopathology and frequently occur interchangeably in a given individual falling in this category ... The clinical picture in such cases often has, superimposed upon it, anxiety reaction which is typically psychoneurotic". The three main subtypes which make up this diagnostic category are:

a) Passive-dependent type: This reaction is characterized by helplessness, indecisiveness and a tendency to cling to others as a dependent child to a supporting parent.

b) Passive-aggressive type: The aggressiveness is expressed in these reactions by passive measures, such as pouting, stubbornness, procrastination, inefficiency and passive obstructionism.

c) Aggressive type: A persistent reaction to frustration with irritability, temper tantrums and destructive behaviour is a dominant manifestation. A specific variety of this reaction is a morbid or pathologic resentment. A deep dependency is usually evident in such cases.

Three subjects, or 1.3 per cent, were found to represent the compulsive personality type which is characterized by chronic, excessive, or obsessive concern with adherence to standards of conscientiousness or of conformity". These individuals "may be overinhibited, overconscientious, and may have an inordinate capacity for work ... The reaction may appear as a persistence of an adolescent pattern of behaviour, or as a regression from more mature functioning as a result of stress".

One subject appeared to fit the description of personality trait disturbance, other. This label is applied to individuals who are unable to maintain their emotional equilibrium and independence under minor or major stress because of disturbances in emotional development. In these cases the neurotic features are relatively insignificant and the basic personality maldevelopment is the crucial distinguishing factor.

e) Sociopathic Personality Disturbance. - Contrary to the expectation frequently held by physicians in connection with alcoholics, typical sociopathic personality disturbance was diagnosed only in 5 instances (2.1%) as the presenting disturbance. Persons of this category "are ill primarily in terms of society and of conformity with the prevailing cultural milieu, and not only in terms of personal discomfort and relations with other individuals". They "are always in trouble, learning neither from experience nor punishment, and maintaining no real loyalties to any person, group or code". They are markedly emotionally immature, "with lack of sense of responsibility, lack of judgment, and an ability to rationalize their behaviour so that it appears warranted, reasonable and justified".

One subject was labelled as transient situational personality disturbance because of the obviously transient character of the subject's disorder, apparently representing an acute symptom response to a situation without apparent underlying personality disturbance.

f) Additional Features. - One subject was mentally retarded on the moron level without showing symptoms and signs of emotional or mental illness.

Two subjects showed no apparent personality disorder but were suffering from epileptic manifestations of the grand mal type.

In 20 (8.4%) cases in our sample the diagnosis of epilepsy was made on the basis of the subject's history and confirmed through hospital records and electroencephalographic findings. In 5 of these cases there were clinical signs of organic brain damage, while the majority had to be considered as suffering from idiopathic epilepsy. From their history it was not possible to obtain a clear picture of the relationship between excessive alcohol consumption and epileptic manifestations. The latter may have been triggered by alcohol, and the treatment neglected through indifference, drunkenness, incarceration, etc. On the other hand, the disease, epilepsy, may have contributed to the alcohol addiction for psychological reasons such as the feelings of rejection and insecurity experienced by the epileptic patient, and his desire to overcome his feelings of inferiority and to be socially accepted through drinking with healthy persons. R. Smart, in his

attempt to evaluate the evidence for the relationship between alcohol and epilepsy, has concluded:

> It seems likely that epileptic states are affected unfavourably by alcoholic consumption; that excessive consumption of alcohol can precipitate epileptoid seizures in withdrawal states; and that epileptics are more susceptible to alcoholism. However, there is insufficient evidence to support the contentions that alcoholism can precipitate latent epilepsy; that alcoholism can "cause" epilepsy... (63,p.20).

Clinical signs of organic brain damage were found in 7 (2.9%) of the cases (5 of them the epileptics mentioned above) but it is probable that additional cases, not detectable in a psychiatric interview, would be uncovered through a suitable battery of psychological tests. While chronic excessive drinking is the most likely cause of cerebral lesions, some individuals may have suffered damage to the central nervous system early in life or sustained head injuries during drinking bouts. Brain damage may, in turn, make pre-existing psychopathologic features more pronounced.

Overt homosexual experience was admitted to by six men in our sample. However, latent homosexual drives influential in enhancing heavy drinking could be suspected from the subject's life history and drinking patterns in 51 cases, although this suspicion was only vague and the latent homosexuality by no means proven. Proving it would, of course, require prolonged dynamic psychological investigation which was impossible under the given circumstances.

The subjects' intelligence and general information were assessed by their responses to pertinent questions asked during the interview. My impression was that the majority were of an intelligence level not much different from that of the average person in the general population, although there were individuals of borderline or defective intelligence alongside with persons of superior intelligence in our sample. This impression, however, was not borne out by the findings of the psychological investigators using more refined psychological tests than the practical methods used in psychiatric interviews. According to these findings the drunkenness offender group on the whole is below average intelligence, at least five IQ points below that found in the general population. This is in keeping with the findings of Feeney et al. (18).

Comparison with Other Studies

Among the studies in the literature containing diagnostic categories two were found to lend themselves for comparison with the diagnostic categories in the present study. The Washington study of Feeney et al. (18) is based on investigations of an incarcerated population of drunkenness offenders, not necessarily either chronic alcoholics or chronic offenders. It is possible that this workhouse population is more typical of the Skid Row population at large than our sample. On the other hand, Myerson's findings at the Long Island Hospital, Boston (47) are derived from the study of alcoholics presenting the picture of severe illness or withdrawal syndromes, apparently with strong dependency needs leading to voluntary hospital treatment. Patients with organic brain syndromes were eliminated from the Long Island Hospital study from the outset. In contrast to these populations the subjects in the present study consist solely of a jail population of clearly defined chronic drunkenness offenders, men with at least 3 convictions in 12 months. However, the relatively rigorous police enforcement of the public intoxication statute in Toronto may mean that even individuals without serious disturbances have a good chance of being caught in the process of the revolving door. The difference in the selection of the three populations may explain in part the differences in diagnostic frequencies, but differences in psychiatric approach may also be involved.

TABLE XV-2

PSYCHIATRIC DIAGNOSES OF THREE GROUPS OF DRUNKENNESS OFFENDERS

	Workhouse, Washington[a]	Long Island Hospital, Boston[b]	Don Jail Toronto
Psychoneuroses	20.0	-	36.2
Psychotic Disorders	30.0	5.9	3.8
Borderline Psychotic	18.0	22.8	-
Personality Trait Disturbance[c]	8.0	54.5	46.0
Personality Pattern Disturbance	6.0	-	10.0
Brain Syndrome without Psychosis	10.0	-	-
Sociopathic Personality	8.0	6.9	2.1
Other	-	-	1.7
Undiagnosed	-	9.9	-
(Number)	(50)	(101)	(237)

[a] Feeney, et al. (18)

[b] Myerson, D.J. (47)

[c] All passive-aggressive personalities except 5 in Toronto sample.

In the Workhouse population 20 per cent were diagnosed as presenting psychoneuroses, none in the Long Island Hospital Study and 36.2 per cent in the present study. Psychotic disorders and borderline psychotic patients were diagnosed in 48 per cent of the Workhouse population, in 28.7 per cent of the Long Island Hospital patients and only in 3.8 per cent in the Toronto sample. While personality trait and personality pattern disturbance were diagnosed in only 14 per cent of the Workhouse population, the Long Island Hospital's and Toronto's figures were significantly higher - 54.5 per cent and 56 per cent respectively. The diagnosis of sociopathic personality was made in a relatively small number of cases in all three studies - 8 per cent in the Workhouse population, 6.8 per cent in the Long Island Hospital population and 2.1 per cent in the Toronto population.

The occurrence of sociopathic personality types is conspicuously low in our sample as compared with the findings in the two other studies.

The literature on alcoholism at large reflects a discrepancy between the relatively high proportion of alcoholics diagnosed as psychopathic personalities and the small number in our sample. In Wall's opinion (70), for example, the psychopath is the type most frequently found among alcoholics. Berner and Solms (7) diagnosed psychopathic personality in 56 cases in a series of 100 female patients admitted for alcoholic psychoses to the Vienna University Neuropsychiatric Hospital. In another study, Button (12) made the diagnosis of psychopathic personality in 14 per cent of his cases. Leonhard (39), on the other hand, came to the conclusion; that alcoholics are not usually psychopaths but many are psychopath-like as far as their attitudes and acting-out are concerned. Frame and Osmond (20) were able to draw the interesting and, in my opinion, valid conclusion from their studies on alcoholics with the use of the Minnesota Multiphasic Personality Inventory - that there exists a psychopathic reaction type as distinct from the psychopathic personality. Their follow-up study showed that only 28 per cent of the alcoholic patients initially diagnosed as psychopathic personality are truly such. The majority should actually be considered as psychopathic reaction types. On the other hand the lapse of time may have brought about changes in the subject's behaviour which would account for a change in those symptoms and signs commonly taken into consideration in constructing a psychiatric diagnosis.

PSYCHOPATHOLOGICAL CONSIDERATIONS

The interviews with these Skid Row alcoholics did not reveal a clear cut picture of a specific personality type or condition responsible for their present mode of life. Instead, it appeared that a series of circumstances and events in their life histories had combined with the variety of emotional and personality disorders discussed above to bring about the shift from the generally accepted social groups and ways of life to the deviant patterns of Skid Row.

The attendant loss of self-esteem, in association with strong masochistic tendencies, seemed to be responsible for making the majority of persons in our sample inert, and unable and unwilling to seriously plan or implement any changes in their lives. These features are characteristic of the depressive conditions and the dependent personality types found in relatively large numbers in our sample. They seem to indicate a breakdown of the defence mechanisms following a prolonged and unsuccessful struggle for the attainment of self-identity, maturity and independence.

Even in the few cases where the subject expressed an intention to take steps to leave Skid Row there was no evidence of a plan based on a determination strong enough to be translated into action. On the contrary, the writer had the impression of a series of rationalizations used as defence mechanisms to protect the remaining part of a badly shaken ego. In most instances it became clear that most of the subjects had fatalistically accepted their way of life on Skid Row and their drinking as the only adjustment available to them, although the discontent they expressed seemed to indicate that they still retained some of their former values and, perhaps, even some vestige of hope.

In this context it is interesting to recall Menninger's ideas (45) about the phenomenon of self-destruction by repeated excessive drinking of alcohol. Alcoholics seem to have an irresistible impulse to throw

away all obligations and opportunities and "bring their house of cards tumbling about their heads". Many formerly successful men, and others who were potentially successful, have literally ruined their lives in that peculiar way, which is alcoholism. The Skid Row men, who had less to begin with, have been able to bring about their ruin more quickly and thoroughly. It is paradoxical that a substance which gives pleasure, relief and stimulation to man, should for some individuals become an instrument of self-destruction.

As far as the men's attitude to the law, its enforcement, imprisonment, treatment of alcoholism, and outlook for the future are concerned, their replies to pertinent questions or their spontaneous remarks varied a great deal. Their opinions could not be expected to be objective or compatible with those held by the majority of our contemporary society, because of the nature of their experience and their emotional and personality makeup. Two out of three of the subjects expressed strong criticism against the law and its enforcement, which they felt to be discriminatory and needlessly severe.

On the other hand, many thought prison had certain beneficial effects in that it kept them from drinking and gave them a chance to recuperate, although they felt that they were given more time than was necessary for this.

Some appeared to have unconsciously accepted life in jail as an adequate way to cater to their dependency needs, and to take care of all their physical needs at the same time apparently also catering to their masochistic tendencies. They frequently expressed criticism of the amount of idle time they had in jail - indicating that it gave them too much time to ponder over their present way of life, thus bringing to the fore feelings of anxiety, tension and depression. On a more objective level, some complained that they had lost their jobs, rooms and personal belongings through prolonged detention, and they felt it would be impossible to recuperate after their release from jail. Many subjects expressed their feelings of hopelessness concerning the day of their release when they would find themselves on the street, with creased clothing carrying the odour of jail, without friends, or even carfare, without a place to go to and without a job. They were conscious that

the only milieu in which they would be accepted in this state and without questions would be Skid Row.

The tendency of these men to have little or no contact with women raises questions about the relationship of latent homosexuality to their way of life. According to psychoanalytic theory, following the loss of, or disappointment in, an object, there is a tendency to regress from the level of object love to that of identification. The homosexual man identified himself with his frustrating mother in one particular way, namely, like her, he loves men. The wish for sexual gratification with the mother is transformed into the wish to enjoy it in the same way as the mother. The father becomes the object of love, and the individual strives to submit himself to the father as the mother does, in a passive receptive manner. Addiction to alcohol may serve as a substitute for overt homosexuality, in part because drinking so frequently involves male camaraderie.

The theory of homosexuality underlying this has been attacked by E. Bergler (4,5,6), who regards homosexuality as a complicated defence mechanism rather than as a drive. The effect of alcohol cannot be to bring to the surface a non-existent drive. Rather, homosexuality camouflages the oral masochistic regression the afflicted person tries to escape. According to Bergler's theory, every orally regressed person fights his losing battle with the image of the pre-oedipal mother. In this battle, one of the techniques used in denying that conflict may be the following formula: "How can I be accused of masochistic submission to mother if I am really interested in the man?"

Interesting and thought-provoking as these theories are, they are extremely difficult to prove, both in the case of an individual alcoholic and in the large heterogenous group of persons labelled as alcoholics. If homosexuality plays a role in the etiology of alcoholism, it cannot be but one of a number of emotional and physiological disturbances which find their expression in the individual's preoccupation with alcoholic beverages and their use in excessive amounts. As mentioned above, signs of homosexuality were found in less than one-quarter of the men in our sample.

The vast majority of psychological disorders diagnosed in our sample comprise neurotic conditions in the broadest sense, and personality trait disturbances. This

finding is not surprising if alcoholism is regarded as a psycho-social disorder in which a part is played both by the predisposed personality of the patient and by his life situation. Both the neurotic and the person presenting personality trait disturbances are known to experience serious difficulties in developing and maintaining mature interpersonal relationships. Their immature relationships, together with unresolved early emotional conflicts, create anxiety, depression and their physiological concomitants for which alcohol is easily found as a quick, though transient, remedy.

But this leaves unanswered the question as to why only a relatively small number of the neurotics and others presenting personality disorders who have chosen alcohol as their means to cope with their problems find their way to Skid Row. Are the personality disorders of these persons so much more severe or are they of a different nature than the alcoholic who is still able to maintain emotional and social ties accepted by our society? Presumably an answer to this question could be found only on the basis of a detailed comparative psychological study of Skid Row and non-Skid Row alcoholics, keeping in mind that the social and emotional isolation of Skid Row life may add considerably to the original disorder - rendering it more profound or even changing its face.

ALCOHOLISM IN THE SAMPLE

In the case of a chronic drunkenness offender, alcohol no doubt plays a major role as far as his physical, mental and social condition is concerned. Chronic alcoholism as described by the World Health Organization is excessive intake of alcoholic beverages which causes psychological, physical and social damage. Various types of classification have been developed, some of them stressing the underlying psychological factors, others the addictive factors and still others the consequences. However, precisely defined types of alcoholism can hardly be applied to the chronic

drunkenness offenders, mainly due to their erratic mode of life and alcohol consumption. The timing and length of drinking episodes are subject to vicissitudes, such as arrests and jail sentences, that are beyond their control.

Any attempt at understanding the psychological functions of drinking for the chronic drunkenness offender must be based on his own account and the inferences that can be made from it. Most of the men gave psychological reasons for starting drinking bouts - depression, loneliness, hopelessness, anxiety, tension, boredom, etc. These feelings they frequently attributed to such objective hardships as lack of employment or a place to live. They made it clear that in all of these and in similar situations, alcohol is almost always available to them. They assert that it is easier to obtain than food, shelter, clothing, drugs, and employment. If they cannot raise the money themselves they can usually find others who have alcohol and are ready to share it. This was given as one of the reasons for sticking to the areas of the city abundant with people who share their problems and seek relief through similar means, areas also abundant in liquor outlets, bootleggers, and police officers. Alcohol may not always be as readily available as they contend, but the idea that it is apparently seems to give them at least a minimum amount of emotional security.

The drinking habits of a great number of the Skid Row alcoholics in our sample differ significantly from those of the average alcohol consuming and alcoholic populations. The most obvious peculiarity is that they usually drink in groups made up entirely of male Skid Row alcoholics. Their drinking of cheap wine usually takes place of necessity in lanes or other hiding places. Although the members of the group may have very little in common except their present way of life and their addiction to alcohol, they seem to place great importance on togetherness for the purpose of drinking. The bottle is circulated among the members of the group who usually do not attempt to take more than their share.

The drinking in groups presumably denotes the last vestige of the need for others in otherwise totally alienated persons. They are able to tolerate the company of their peers because there is no social pressure involved as compared to other types of social gathering. The bottle gangs assemble solely for the purpose of

drinking, following which each participant may go his own way without questions being asked. Sharing from the same bottle may serve to enhance the feeling of temporary closeness amongst the members of the group by expressing an unconscious symbolic meaning. When they are outside of jail, alcohol in general and its consumption in a group of peers may act as a substitute for the jail's fulfillment of unconscious needs for dependence and protection. The lack of a craving for alcohol that the men say they experience in jail may, in turn, be related to the fact that their dependency needs are met in this setting.

Virtually all our subjects have lost control over their drinking during their years of addiction to alcohol in the sense of being unable usually to stop drinking after the first few drinks. On the other hand, they have shown an ability, now and again, to abstain from drinking outside of jail for periods ranging from days to several weeks. In the interviews the men reported periods of abstinence of up to seven days in 52 cases (22.6%); two weeks to one month in 61 cases (26.3%); one to three months in 54 cases (23.3%); and over 5 months in 6 cases (2.6%).

In all but three cases of chronic alcoholism the subjects had experienced one or more of the aftermaths of excessive drinking, among them severe "hangovers" with tremors, with or without the need of "morning after drinks", blackouts, hallucinosis, "shakes", and delirium tremens. The hangovers were described as a highly complex mixture of physical illness with anxiety, tension, and some depression, frequently with guilt feelings and remorse. The blackouts experienced by a great number of subjects corresponded to the picture of complete or incomplete amnesia, with considerable variation in their duration. It was not possible to determine to what extent they were due to transient pathological brain processes, and/or to hysterical mechanisms, the former being toxic in nature but perhaps also, in some instances, following brain concussion through falls, blows, etc. while intoxicated.

If hysterical mechanisms are implicated, they may be similar to those underlying psychogenic amnesia in which recall is inhibited for psychologic reasons. We may be dealing here not with a passive loss of memory traces, but with an active defence against experiences which appear unbearably anxiety-producing or painful. The individual conscious mind might find the memory of an actual event too painful to face, and therefore repress the event and keep it repressed for an indefinite period of time.

Regarding delirium tremens, several subjects gave clear descriptions of this condition with restlessness and visual hallucinations as the main symptoms, remembering it as a highly frightening experience. On the other hand, what several subjects described as "shakes" or "being close to D.T.s" did not seem to fit any clearly defined clinical picture. In some instances these conditions may have been abortive cases of delirium tremens, in others perhaps, acute anxiety attacks. In a number of cases, however, the subjects described auditory hallucinations, either alone or simultaneously with their visual hallucinations. On the ground of one interview it did not seem possible to determine whether some of these conditions were alcoholic hallucinoses or perhaps acute schizophrenic reactions of the paranoid type. Some of the hallucinations remembered from attacks of delirium tremens were very interesting in that they expressed the censuring and threatening actions of the individual's superego, being counteracted by defence mechanisms aimed at supporting the subject's badly weakened ego.

According to Thompson (69), delirium tremens is the direct result of the effect of alcohol on the brain. It is unknown why one alcoholic will develop D.T.s and another acute hallucinosis, unless it is due to the individual susceptibility of nerve cells. No other toxic substances produce either disorder, alcohol being the only etiologic factor identified.

Himwich (25) has shown that alcohol interferes with the nerve-cell metabolism of carbohydrates. In his view it is some phase of this interference which results in the development of D.T.s. It is not due to vitamin or other nutritional deficiencies. This viewpoint is not shared by Kirchof et al. (35) who believe that deficiencies play an important role in the development of this condition.

From a psycho-analytical viewpoint Tausk (67) has interpreted the alcoholic occupational delirium as the expression of sexual excitement in patients who are erotically stimulated and at the same time rendered impotent by alcohol, and who are, on deeper levels, homosexual and narcissistic.

In recent years interesting viewpoints were published by German psychiatrists, notably Schulte (61) and Bilz (8). They question the view that delirium tremens

is solely organic in origin. The person in his free decision may be involved, at least indirectly, in its provocation and manifestation. Examples of attacks of delirium tremens following extremely serious psychologically motivated agitation were reported.

The generally accepted view is that delirium tremens is a genuine organic reaction - as a dangerous but, to a certain extent, purposeful, disaster reaction. It is considered to be a kind of self-regulatory, centrally-directed metabolic reaction in a deleterious situation, a sort of last attempt, though fraught with danger, to turn the steering wheel in order to prevent a complete breakdown. In his attempt to escape his terrible fear through senseless activity, the patient offers the picture of a hunted creature overpowered by the authority of his conscience. The superego - which Fenichel (19) has described as that part of the mind which is most easily soluble in alcohol - rises in grotesque exaggeration.

Seen from the anthropological viewpoint, delirium tremens is a disaster reaction which contributes to survival. Some alcoholic patients who are unable to develop D.T.s deteriorate completely, in analogy with certain epileptic patients who are unable to develop convulsions and deteriorate into chronic epileptic conditions. This is in keeping with the observation that patients who have had D.T.s, generally speaking show more stamina and have a better prognosis than other alcoholics. Delirium tremens may cause the alcoholic to reorient his life. No evidence of this was found in our sample, perhaps because whose who did reorient themselves disappeared from the chronic offender population.

Most of the subjects reported that they started drinking socially in their adolescence shortly after quitting school, a fact compatible with the average drinking experience in the non-alcoholic population (41). They tried to establish a group identity with their peers, and at the same time started going out with girls. Both of these new social activities apparently entailed stressful situations which in some instances would have increased their feeling of inadequacy if not for the helpful effect of alcohol in allaying their inhibitions and anxieties. This does not necessarily constitute the expression of lasting psychopathology and there is no proof that it is likely to result in alcoholism. However, it does establish a pattern that may develop into true dependence if prolonged stress is encountered later in life.

Many subjects started or intensified a heavy drinking pattern while in the Armed Forces. From a psychological viewpoint there are conflicting pressures in the military situation. There is a feeling of security - the individual soldier has limited but clearly defined responsibilities while all his needs are taken care of. This same situation, however, may create stress at an age when young men are ambitious to prove their ability to establish themselves as adult responsible members of society and to care for a family. In addition to this comes boredom, monotony, and necessary but frequently frustrating discipline. An additional factor may be the stimulating effect of an all male environment on latent homosexual drives.

This army experience, together with other experiences in other all-male work situations, such as railway gangs and lumber camps, reinforced a pattern of heavy peer-group drinking. Later, lack of work, estrangement from their families, and lack of a home added to the psychological reasons for drinking. In most instances, the reasons given by the men for their current drinking reflect this. They say that they drink because they feel depressed, lonely, anxious, hopeless, bored, etc. Alcohol, consumed in the company of others like themselves, is often the most easily available means of relief.

CIVILIZATION AND THE INDIVIDUAL

Freud has described happiness as the result of the satisfaction of needs which have been dammed up to a high degree. By its very nature happiness is only possible as an episodic phenomenon. Whereas man's opportunities for happiness are restricted by his constitution, unhappiness can be experienced with less difficulty, and man's task of avoiding suffering outweighs that of obtaining pleasure. Man is threatened with suffering from three directions: 1) from his body, 2) from the outside world, and 3) from his relations to his fellow men, the latter producing the greatest suffering. One of the methods used as a defence against this type of unhappiness is voluntary isolation, keeping oneself aloof from other

people. To avert suffering which comes from the individual's own body he will use methods to influence the body's sensations. Alcohol is highly effective for this purpose as it not only causes pleasurable sensations but renders the individual less capable of receiving unpleasurable impulses. In Freud's own words:

> The service rendered by intoxicating media in the struggle for happiness and in keeping misery at a distance is so highly prized as a benefit that individuals and peoples alike have given them an established place in the economics of their libido. We owe to such media not merely the immediate yield of pleasure, but also a greatly desired degree of independence from the external world. For one knows that, with the help of this 'drowner of cares' one can at any time withdraw from the pressure of reality and find refuge in a world of one's own with better conditions of sensibility. (21, p.78)

Another method of avoiding suffering consists in influencing one's instinctual impulses even to the point of killing them. Still another method for averting suffering is the use of the displacement of libido, that is, by sublimation of the instincts.

Another procedure consists in loosening the individual's ties with reality and obtaining satisfaction from illusions. Although the individual recognizes them as illusions the discrepancy between them and reality does not interfere too much with his enjoyment. Some persons regard reality as their sole enemy and the main source of all suffering. They feel it is impossible for them to live with reality and therefore must break off all relations with it in order to experience happiness.

Speaking of that way of life which looks for all satisfaction in loving and being loved, Freud distinguishes three main personality types:

> The man who is predominantly erotic will give first preference to his emotional relationships to other people; the narcissistic man, who inclines to be self-sufficient, will seek his main satisfactions in his internal mental processes;

> the man of action will never give up the external world on which he can try out his strength. (21, p.83).

Further:

> A person who is born with a specially unfavourable instinctual constitution, and who has not properly undergone the transformation and rearrangement of his libidinal components which is indispensable for later achievements, will find it hard to obtain happiness from his external situation, especially if he is faced with tasks of some difficulty.(p.84).

And:

> The man who sees his pursuit of happiness come to nothing in later years can still find consolation in the yield of pleasure of chronic intoxication. (p.84).

Speaking of the social source of human suffering, Freud contends that what we call civilization is largely responsible for our misery.

> A person may become neurotic because of his inability to tolerate the amount of frustration which society imposes on him in the service of its cultural ideals ... the abolition or reduction of these demands would result in a return to possibilities of happiness. (21, p.87).

Although advancement in the fields of science has given man unprecedented control over nature, for example, in the field of medicine it is not sufficient to make for human happiness. In Freud's definition:

> ... the word 'civilization' describes the whole sum of the achievements and the regulations which distinguish our lives from those of our animal ancestors and which serve two purposes - namely to protect men against nature and to adjust their mutual relations. (p. 89)

However, our demands on civilization go beyond protection and utilization of the earth's resources. We expect civilization to value beauty and to establish sets of rules concerned with cleanliness and order. Assuming in a general way that the motive force of all human activities is a striving towards the two confluent goals of utility and a yield of pleasure, it can be supposed that this also holds true of the manifestations of civilization.

However, one of the most characteristic features of civilization is the manner in which the social relationships are regulated. Life in a community is possible only

> when a majority which is stronger than any separate individual is formed and remains united against all separate individuals ... This replacement of the power of the individual by the power of the community constitutes the decisive step of civilization. (21, p.95)

The individual's liberty is not a gift of civilization. On the contrary it was greatest before there was any civilization.

> What makes itself felt in a human community as a desire for freedom may be their revolt against some existing injustice, and so may prove favourable to a further development of civilization; it may remain compatible with civilization. But it may also spring from the remains of their original personality, which is still untamed by civilization and may thus become the basis in them of hostility to civilization. The urge for freedom, therefore, is directed against particular forms and demands of civilization or against civilization altogether. (21, p.96).

There is a striking similarity between the process of civilization and the libidinal development of the individual. Civilization is built upon a renunciation of instinct. The non-satisfaction of powerful instincts, this "cultural frustration" dominates the large field of social relationships between human beings. If an instinct is deprived of satisfaction and the loss is not compensated for economically, serious disorders may be expected.

Among the influences on the development of civilization Freud mentioned the compulsion to work created by external necessity, and the power of love which made the male unwilling to be deprived of his sexual object and the woman of that part of herself which had been separated from her - her child. Thus Eros and Ananke (Love and Necessity) as Freud puts it, have become the parents of human civilization. Man's discovery that sexual love yielded him the strongest experiences of satisfaction was associated with a dangerous dependency on part of the external world, namely his chosen love object. Genital love leads to the formation of new families whereas more generalized love (e.g. love of mankind) leads to the establishment of friendship relationships which are less exclusive. An inevitable conflict arises between the family and the community. One of the main endeavours of civilization is to bring persons together into large units but the smaller family unit is unwilling to give up the individual. Every young person is confronted with the task of detaching himself from his family. Society helps him overcome the difficulties inherent in this process by means of puberty and initiation rites.

The tendency on the part of civilization to restrict sexual life for instance, through monogamy, does not interfere to an excessive degree with the "normal" individual. Nevertheless, the sex life of civilized man is seriously impaired and its importance as a source of happiness has considerably diminished. Neurotic persons, unable to tolerate the frustrations of sexual life, create substitutive satisfactions through their symptoms.

Civilization is not content with the individual's libidinal ties to another individual. It works toward binding the members of the community together using every means at its disposal to facilitate the establishment of strong identification between the members of the community. Restrictions on sex life appear unavoidable.

Among man's instinctual endowments, says Freud, there is a powerful share of aggressiveness. Civilization has to use its utmost efforts in order to set limits to these aggressive instincts since it is not easy for men to give up the satisfaction derived from their own aggressiveness.

If it is true that civilization imposes great sacrifices both on man's sexuality and aggressiveness it is easier to understand why he finds it so difficult to be happy in that civilization. We again quote Freud's words:

> When we justly find fault with the present state of our civilization for so inadequately fulfilling our demands for a plan of life that shall make us happy, and for allowing the existence of so much suffering which could probably be avoided - when, with unsparing criticism, we try to uncover the roots of its imperfection, we are undoubtedly exercising a proper right and are not showing ourselves enemies of civilization. We may expect gradually to carry through such alterations in our civilization as will better satisfy our needs and will escape our criticisms. But perhaps we may also familiarize ourselves with the idea that there are difficulties attaching to the nature of civilization which will not yield to any attempt at reform. Over and above the tasks of restricting the instincts, which we are prepared for, there forces itself on our notice the danger of a state of things which might be termed 'the psychological poverty of groups'. (21,p.115)

Theory of the Chronic Skid Row Alcoholic

Freud's paper, Civilization and Its Discontents which has become a classic, was summarized at some length because of the writer's impression that it has particular significance for the understanding of the psychology of the chronic drunkenness offender. Since most individuals who drink to excess, even chronic alcoholics, do not become Skid Row chronic drunkenness offenders, it is logical to seek the psychological and social factors which make some men end up in this condition. This paper will attempt to show that C.D.O.s are persons who have been unable to deal with frustrations to their sexual and aggressive instincts through the usual channels of sublimation and integration into a large society with its substitute satisfactions. In essence, Freud argues that the main causes for man's discontent in civilization are the severe restrictions which civilization puts on those two basic instinctual drives - sex and aggression. The average fairly well-adjusted person finds his ways and means to cope with

everyday frustrations and situations, including those crises which invariably befall him during his lifetime. The normal man is able to establish workable human relationships which by necessity will consist of normal give-and-take interaction, even though this frequently means learning the hard way - by experience, accepting repeated blows to his security and threats to his ego. In spite of this adjustment his discontents with life in a civilized society will come to the fore on occasion, particularly at times of internal or external crises, and will necessitate the development of new devices to help cope with his frustrations. He may "get away from it all" by a complete change of environment and scenery, breaking away from repetitive obligations, chores and encounters, which will give him the transient gratification that he is able to shake off the yoke of civilization and be master of his own world. In most instances this aim is met by using those facilities only society can put at his disposal, for instance, those extensive means of travel which only civilization affords.

The frustrations caused by the restrictions on civilized man's aggressiveness can also be eased by various means of sublimation such as artistic, literary and scientific work; sports; community, political, religious and charitable work; and gratification derived from his relationship with his family and friends. But these channels for sublimation are not available to individuals who due to their personality makeup and, in some instances, to emotional or mental illness are unable to make the minimum contribution necessary to maintain social relationships. They are unable to give and become disappointed whenever they are not, in turn, given what they expect to obtain. Whether this refers to material things or emotional relationships is not important since material give-and-take implies emotional motivation and exchange.

As Freud (21) pointed out, intoxication is one of the means of escaping the frustrations imposed by society, an opinion that appears to be accepted by most students of alcoholism. Although intoxication has only a temporary effect, it is at the threshold of chronic alcoholism, which in turn may lead to another escape from the frustrations of civilization, namely isolation.

Isolation may be considered one of the severest expressions of psychopathology in that it severs the most human of man's qualities - his ability to live with

his fellow men irrespective of his motives for association. Life in isolation and particularly on Skid Row means life without any close ties, without obligations and work, without responsibilities and without moral concern. It is life at the lowest social, economic and cultural level one can imagine in our contemporary western society.

The fact that the chronic drunkenness offender does not avoid arrest and conviction is only in apparent contradiction to his withdrawal from society, his isolation and renunciation of duties and rules. In his persistence in staying in districts of the city where arrest is highly probable one can see a repetition compulsion denoting deep seated psychopathology, and also an expression of aggression in the shape of disobedience to laws he is well aware of through his own experience. On the other hand, life in jail requires only a minimum of obedience to a set of rules and is a fairly good example of complete passivity. It also fulfills the immature desire to be taken care of by society and, on a deeper layer, by a parental substitute.

As far as the chronic drunkenness offender's descent on the social ladder is concerned, his starting place tends to be at the lower end of the social scale. This apparently facilitates his descent to Skid Row in contrast with those chronic alcoholics and emotionally and mentally ill people from the upper levels of society who rarely find their way to the bottom level.

In summary, then, the chronic Skid Row alcoholic is an individual whose passivity, either as a presenting personality trait or one embedded in a manifest emotional or mental disorder, interferes to the highest degree with an adequate response to the frustrating experiences caused by the restrictions on sex drive and the expression of aggression imposed by civilization. Since he is lacking in ability to counteract his frustrations by means of sublimation in the broadest sense of this word and unable to tolerate the frustrations inherent in social duties and responsibilities, he may use two devices - intoxication and isolation - to deal with his emotional and social predicament. The probability of his doing so increases if he is at a social level that makes these modes of adaptation more accessible than others.

In an attempt to apply this theory to our findings it appears necessary to review the psychiatric diagnoses listed in Table XV-1, as well as the other findings

referred to in this paper. Do the personality types and the emotional and mental disorders diagnosed in this sample imply a very high degree of dependence, of inability to cope with the stressful situations of everyday life and particularly with increased stress due to situations demanding mature actions and reactions rather than dependence? Do they imply, furthermore, a tendency to be easily hurt and to respond to threats or blows to the ego with withdrawal? Finally, do the subjects come from social levels in which there was little protection against social descent and from which the downward way was not difficult? A review of the aforementioned table shows that 50 per cent of the subjects were diagnosed as schizophrenic reactions, schizoid personalities or passive-aggressive personalities. These have in common the anticipated character features to a very high degree: emotional vulnerability, high amount of dependence, inability to give rather than take, inability to assume responsibilities society imposes on the adult, and a tendency to withdraw under increased stress. In those diagnostic categories in which the depressive element plays an important part (depressive reactions, manic-depressive reactions, cyclothymic personalities, and emotionally unstable personalities) similar features can be found underlying or associated with the depression.

Although it may be argued that to a certain extent these features can be found in a great number of persons representing both the so-called general population and the morbid group of people called chronic alcoholics, it is not difficult to see that in the individuals who end up as chronic drunkenness offenders the psychological and social characteristics described are both more common and more pronounced. Thus the chronic drunkenness offender in our sample emerges as a person with a pronounced personality disorder in which strong dependency needs are associated with high emotional and social vulnerability, a strong tendency to react to stressful life situations with isolation and withdrawal, showing his discontent with civilization to an excessive extent and as a permanent adjustment in contrast with the person whose ego is better protected by nature, past experience and social environment.

THE NATURE OF THE OFFENCE

Despite the spread of the "disease concept of alcoholism" (31), we find the antagonistic and punitive attitude still prevailing in some sectors of our society; notably in the law and its enforcement, but also among social agencies, medical doctors, and in hospitals. The punitive attitude against the subjects of our study seems to be the most important single factor accounting for the perpetration of the problem. Generally speaking, this punitive attitude is reminiscent of that frequently encountered in the dealings of parents and educators with children, and the reactions of the subjects resemble the child's inappropriate reactions. Such treatment is apt either to reinforce the individual's dependency needs or to cause him to react with spite which, in turn, enhances the existing tendency to isolate himself. These processes are complicated and interwoven and presumably co-exist although they were not necessarily established at the same time.

Since in this study we are dealing with "offenders" we must take into consideration not only their personality, but also the nature of their "offence", the person or persons who are suffering through this offence, and the effects on the community.

As far as the "offence" is concerned, there is no doubt that the subject has acted against the law provided he has actually appeared in a state of drunkenness in a public place. Immediately we are confronted with a number of questions. By what diagnostic method was drunkenness diagnosed and proven? By whom was this diagnosis made? Was the degree of drunkenness established, and its effect on the offender's state of health, his responsibility and his ability to take care of himself? Did the offender knowingly and wilfully act against the law or was his offence a complication of ill health, in this case alcoholism or excessive intake of alcohol? The answers to these questions are obvious. The state of drunkenness was not diagnosed by a duly qualified professional person and no diagnostic tools were used but the impression of a layman, i.e. the arresting officer, who would be unable to identify the degree of intoxication and its effect unless he were dealing with - a high

or blood - alcohol level.[2] It cannot be assumed that the intoxicated offender acted wilfully and knowingly in appearing in a public place. Perhaps unconscious motives were involved but this could be determined only through methods of depth psychology and would not really alter the point that the act was not a consciously wilful one.

In the vast majority of drunkenness offences, the only "sufferer" or victim (unless the drunk person is molesting people) is the offender who is mainly inflicting harm upon himself.

On the basis of the writer's experience with the drunkenness offenders in this study, a comparison with a group of fairly important conditions known as "iatrogenic" conditions comes to mind. An "iatrogenic" condition is generated by the physician, that is, induced in the patient by autosuggestions based on the physician's examination, manner or discussion. A drunkenness offender is a person who happens to be found in a public place while drunk: a chronic offender being one who has been apprehended repeatedly. Without the law or its enforcement, however, the very same person would simply be an alcoholic or a person having drinking problems, in need of help as a sick person, if the disease concept of alcoholism was applied.

Looking at the offence from the viewpoint of the community, we find a contradiction between the availability and economic implications of alcohol on the one hand, and the punitive attitude to certain alcoholics on the other. In our society alcohol is available to the adult population without many restrictions, it is used widely as an adjunct of social occasions, and the Government derives considerable income from its production and distribution. The very same population and authorities maintain the law and its enforcement in spite of its considerable cost, and its questionable usefulness as therapeutic and correctional agent ... and in spite of many misgivings.

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[2] Even in these cases no allowance was being made for the possibility of the signs of intoxication being caused by drugs alone or in combination with alcohol.

As a member of a community and, at the same time, a professional man on whom the community makes increasing demands for advice and assistance, the psychiatrist should feel free to express his opinion of the law and its enforcement as it affects prevention and therapy. Although the psychiatrist is well aware of the fact that the legislator cannot be expected to base legislation solely on medical views and endeavours, he should attempt to influence legislation in the interests of healing.

Menninger points out that

> in general, the gains and goals of the social offender are not those which most men seek....It is not the successful criminal upon whom we inflict our antiquated penal system....[It is] the clumsy, the desperate, the obscure, the friendless, the defective, the diseased....not the professional criminals (46, p.760).

The crime may be one of impulse or accident. Frequently the offender is a "persistently perverse, embittered, lonely, and resentful individual who has joined the only group to which he is eligible - a group of the outcast and the antisocial" (46, p.760). These mentally and socially sick persons are jailed and eventually returned to society in a condition even less able to cope. Menninger suggests that the present system of dealing with the problem of the offender is "antiquated, expensive and disappointing". Although not specifically aimed at the chronic drunkenness offender, Menninger's argument fits admirably the majority of subjects in our sample.

One distinctive aspect of alcoholism, as compared with other psychological illnesses, stressed by Stanley Rosenman (53,54)is its continued tie with morality religion of the "crusading" variety. Alcoholism is the only psychological illness which has provoked the organization of a morally toned international movement - the temperance movement. As a matter of fact, the present Ontario legislation concerning drunkenness in a public place is the modified outcome of the Canada Temperance Act of 1878, amended 1919 (71).

From the medico-legal viewpoint the offence of being intoxicated in a public place is quite different from that of committing other offences while under the influence of alcohol. Whereas the former is the

expression of a disease process - chronic alcoholism - it is safe to assume that the role of alcohol in many criminal offences is to release aggressions by weakening the individual's superego. Failure to deal with these latter offenders may enhance aggressive tendencies and criminality.

PROGNOSIS AND RECOMMENDATIONS

Prognostication is particularly difficult in the case of chronic alcoholism. Due to the extremely complex etiology and pathogenesis of alcoholism, the natural history of the disease is much less predictable than most other physical and/or mental illness. In many diseases, apart from their natural history, the prognosis can be made on the basis of the known effectiveness of certain treatment methods when applied at certain stages of the course of the disease. But for alcoholism there is no single effective therapeutic method known. Nevertheless, an attempt was made to assess the prognoses in our sample on the basis of the psychiatric interview. In 15 cases (6.3%) the prognosis was assessed as definitely unfavourable, due to the subject's age, social and mental deterioration, the long duration of his condition, and combinations of these factors. Only in 5 instances (2.1%) was it felt that the prognosis could be given as favourable. In the majority of cases (181 or 76.5%) the prognosis was "guarded". We were fully aware of the ambiguity of this term which to be useful, carried such implied provisions as, that therapeutic measures be taken in due course; that the patient be helped in developing a sufficiently strong motivation for treatment; that he develop a working relationship with the therapeutic agency; and that the therapeutic measures would be broad enough to encompass every angle of the problem. When we compared the prognoses of the men in our Toronto sample with those of the two groups described by Feeney et al. (18): the Workhouse group of Court-referred chronic offenders and the voluntary outpatient clinic alcoholics, we found that 32 per cent of the clinic patients were given a prognosis of good or fair to good; none of the Workhouse inmates was given this prognosis and only 2.1 per cent of our chronic offender group. A poor

prognosis was made for only 2 per cent of the Clinic group, 6.3 per cent of the chronic offender group and to almost half (48%) of the Workhouse group. As we would have expected a closer parallel between the Workhouse and our group, the discrepancy can probably be explained by the use of our 'guarded prognosis' category with its numerous aforementioned qualifications.

With most cases in our sample (192 or 81%) it was felt that only the broadest approach to therapy could be hoped to improve the prognosis and yield favourable results. Such an approach would require the ccoperation of the medical profession (general practitioners and specialists in internal medicine, psychiatry and neurology), psychologists, social workers and clergy in a well co-ordinated treatment and rehabilitation program. Given this program, which would also involve well equipped treatment centres, together with the understanding and cooperation of such important bodies of society as industry and trade unions, much more effective work with the chronic drunkenness offender could be achieved than under the haphazard conditions presently employed.

Only with a comparatively small number of cases in our sample would a less involved therapeutic approach be sufficient to guide the men out of Skid Row and into a socially acceptable - and satisfactory - way of life.

Previous therapeutic attempts with our subjects have failed in that they did not curb their excessive drinking or change their life situation sufficiently to enable them to remove themselves from the Skid Row area and their drinking companions. Experience with treatment or Alcoholics Anonymous was reported by 58 per cent of the subjects. AA was mentioned most frequently, followed by the Alex G. Brown Memorial Clinic (a residential centre attached to a Provincial reformatory), the Salvation Army's Harbour Light; and the Clinic of the Alcoholism Research Foundation. Twenty-seven per cent had been patients at two or more of the treatment centres.

Concerning the use of drugs for the treatment of alcoholism in the past, 130 men (47.1%) in our sample never had drug therapy of any kind. Eighty subjects (35%) had been on Antabuse; 4 (1.8%) on Temposil (citrated calcium carbimide); and one subject had been on both drugs at one time or another. Two men reported that they had been offered drugs but had refused using them. Both drugs

are "protective agents" in that the patient's awareness of the distressing toxic symptoms caused by the chemical interaction of the drug and an alcoholic beverage, may assist him to avoid the use of alcohol (1). If the patient is sufficiently motivated to deal with his drinking problem, these drugs are apt to enhance his motivation with the aid of a conditioned reflex. If, on the other hand, his motivation is poor or absent, he may never start using the drugs or may discontinue them at any time.

As far as the subjects' views on the use of drugs in future treatment was concerned only 71 (31.3%) indicated without qualification that they would be willing to undergo drug therapy.

Regarding the large number of subjects (95 or 41%) who had never had any therapeutic contacts: it is by no means exceptional or unexpected. Many chronic alcoholics never request or obtain treatment for their drinking problem or else it comes late in the course of their progressive illness. Twenty-eight subjects (12.3%) said that they would consider using drugs that had no side effects, and seven subjects (3.0%) mentioned other qualifications. The majority of the remainder said that they would not be willing to undergo drug therapy. But even the affirmative answers should not be accepted at their face value. The main reason for so answering appears to be the hope that the mere act of swallowing magic pills would solve the extremely complicated problem of chronic alcoholism and its consequences.

The use of psychopharmacological agents are helpful in the treatment of a variety of psychic symptoms frequently encountered in the alcoholic intoxication and in the withdrawal. The help the alcoholic receives from the medical profession convinces him that he is not being rejected and encourages him to return for further treatment. In view of the established fact that the drop-out rates from therapy are on the whole higher for alcoholics than for general psychiatric patients (14) this appears very important.

In general, the subjects' attitude to treatment did not reveal the existence of strong motivation for treatment and rehabilitation. They directed their criticism and praise at the institutions and treatment programs themselves rather than at their own role in applying for and cooperating in the process of treatment.

While punishment appears unacceptable as a method of therapy, from the viewpoint of psychiatry, involuntary submission to therapy as opposed to voluntary treatment has been a frequent and controversial topic of discussion among psychiatrists (11,24,50,59,60,62,68,72). It should be borne in mind that there is no sharp delineation between "voluntary" and "involuntary" treatment: the alcoholic who requests and undergoes treatment is frequently motivated by pressure from many sources, some subtle, some outright threats (for example, on the part of the spouse, or perhaps the employer). And the alcoholic who is "ordered" or "convicted" to undergo treatment may develop a fair amount of motivation for psychological reasons of his own, which have little to do with his legal condition. Hence, utilizing every available and possible source of motivation for rehabilitation becomes a worthwhile endeavour on the part of the helping professions, and research along these lines appears promising, particularly if contrasted with the present situation.

In the case of the so-called "social diseases" (tuberculosis, venereal diseases, etc.) compulsory treatment was, and still is, needed for the sake of the individual patient and the community. The basic dilemma of any compulsory treatment is that, in spite of education to the contrary, it is experienced as an act of punishment by the individual who is temporarily deprived of his liberty: there is still a conspicuous stigma attached to institutionalization and authoritarian treatment. Compulsion is known to create resentment and hostility and, as a consequence, an environment which is not considered suited for reform and rehabilitation. Also, in the case of alcoholism, the compulsory treatment philosophy is apt to give the general public the misleading impression that an effective cure for alcoholism has been found.

In favour of compulsory therapy with chronic drunkenness offenders is the finding of Margolis et al. (42) that offenders placed on probation and ordered to seek psychotherapy became more involved in treatment than a comparable group of voluntary patients. These authors feel that the vast number of the alcoholics who could be reached through the courts early in their illness suggests the importance of increased attention to offenders. This also shows the need for an association between the medical profession and the courts ... as long as this association is centered on the treatment relationship rather than on the separation of the individual from society.

The problem of treatment and rehabilitation of the chronic alcoholic is no doubt one of the most difficult in medical and social work. The difficulties are conspicuously greater in the case of the alcoholic on Skid Row, who has never attained or else has lost the self-esteem and sense of human dignity on which any successful program of treatment and rehabilitation must probably be based (51,52). He is caught in a downward spiral: lack or loss of self-esteem produces asocial or antisocial behaviour which in turn causes him to be further alienated, and this further impairs his self-esteem. Any therapeutic program would have to break this vicious circle.

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